Parental presence and visiting policies in Italian pediatric intensive care units: A national survey

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Objective: To investigate parental presence and visiting policies in Italian pediatric intensive care units (PICUs).

Design: Descriptive survey.

Setting: All 34 Italian PICUs.

Patients: Patients were not involved in this work. We studied the presence of parents and visiting policies in PICUs in Italy.

Interventions: None.

Measurements and Main Results: A questionnaire was sent to the unit heads. Response rate was 100%. Median daily visiting time for parents was 300 mins; for other visitors, it was 120 mins. Twelve percent of PICUs had unrestricted policies; 59% did not allow the constant presence of a parent, even during the day. Visits from other relatives and from nonfamily were not permitted in 35% and 88% of units, respectively. Policies were not modified for a dying patient in 6% of PICUs. Children’s visits were not allowed in 76% of units. Cardiac surgical PICUs were more likely to have restrictive visiting hours. Parents were permitted to be present at the bedside during ordinary nursing procedures, invasive procedures or cardiopulmonary resuscitation in 62%, 3%, and 9% of PICUs, respectively. No waiting room was provided in 32% of PICUs. Gowning procedures were compulsory for visitors in 94% of units. In 48% of PICUs, a formal process of revising visiting policies was ongoing. On patient admission, 77% of PICUs provided the family with informative material on the unit. Phone information on the patient was given frequently (often/always, 70% of PICUs).

Conclusions: In Italian PICUs, there is a marked tendency to apply restrictive visiting policies, not to allow parents 24-hr access at bedside, and to limit the presence of parents during procedures and cardiopulmonary resuscitation. A revision of current policies has begun, signaling a readiness for change. (Pediatr Crit Care Med 2010; 11:000–000)

Key Words: pediatric intensive care; visiting policies; parents; family; waiting room; gowning procedure
In 38% of PICUs, parents were not normally allowed to be present at the bedside during ordinary nursing procedures, such as endotracheal suctioning. In the case of invasive procedures, such as inserting a central venous catheter and in the case of cardiopulmonary resuscitation, the presence of parents was permitted only in 3% and 9% of units, respectively.

Visitors Other Than Parents. Median daily visiting time for other visitors was 120 mins (range, 0 min–24 hrs). Visits from other relatives and nonfamily (e.g., teachers or friends) were not permitted in 35% and 88% of units, respectively. Children were not permitted to visit in 76% of units.

Waiting Area. No waiting room was provided in 32% of PICUs. Furniture and facilities available to visitors are described in Table 2.

Gowning Procedures and Hand Washing. A gowning procedure was compulsory for visitors in 94% of PICUs (Fig. 2). In all units, visitors were required to wash their hands on entering and leaving the unit.

Revision of Visiting Policies. In 11 (32%) PICUs, there was a working group for the periodical revision of visiting policies, and in 16 (48%) units, a formal process of revising the ward’s visiting policies was ongoing.

Visiting Time and General Attitudes Toward Visitors. A longer visiting period (>300 mins) was significantly associated (Table 3) with abolition or simplification of gowning procedures (p < .01).

Determining Factors for Opening Times. Visiting time seemed to be independently associated with the type of PICU. Cardiac surgery units were less likely to have visiting hours >300 mins/day (odds ratio, 0.13; 95% confidence interval, 0.19–0.92; p = .041).

Informing Parents. On admission of the patient, in 77% of cases, the family was given informative material on the PICU (A4 sheet, 33%; leaflet, 18%; booklet, 21%). Daily meetings of doctors with parents were held systematically in almost all PICUs (97%) and were mainly conducted by the physician on duty (68%) and/or unit head (35%). In 79% of PICUs, a room was specifically provided for meetings with family members.

Information was also given by phone (often or always, 70%; sometimes, 23%; never, 6%). Those authorized to provide this information were mainly physicians (doctor on duty, 94%; charge nurse, 18%; nurses, 35%). Not only reassurance (often or always, 70%; sometimes, 23%; never, 6%) but also generic clinical information (79%), e.g., regarding temperature or sleep. However, even detailed clinical data, e.g., on diag-

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**Table 1. Characteristics of pediatric intensive care units**

<table>
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<tr>
<th>Characteristics of PICUs</th>
<th>n</th>
<th>Percentage</th>
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</thead>
</table>

**Type of PICU**
- Mixed medical-surgical: 20 (59)
- Surgical: 3 (9)
- Cardiac surgery: 9 (26)
- Assigned to Emergency Department: 2 (6)

**Type of Activity**
- Exclusively pediatric: 22 (65)
- Pediatric but also admitting adult patients: 6 (18)
- Pediatric section in adult ICU: 6 (18)

**Type of Hospital**
- University hospital or scientific institute: 18 (53)
- General hospital: 16 (47)

**Number of Beds**
- ≤6: 16 (47)
- 7–10: 10 (29)
- >10: 8 (24)

**Number of Admissions in 2006**
- ≤300: 18 (55)
- 301–500: 8 (24)
- >500: 7 (21)

**Period of Operation**
- <5 yrs: 3 (9)
- 5–10 yrs: 7 (21)
- >10 yrs: 24 (70)

95% confidence intervals were calculated. Analyses were performed using STATA 9 (StatCorp LP, College Station, TX).

**RESULTS**

The response rate was 100%. Table 1 shows the characteristics of responding units.

**Parental Presence and Visiting Policy.** Median daily visiting time for parents (Fig. 1) was 300 mins (range, 30 mins–24 hrs). Of the surveyed PICUs, 12% had unrestricted policies, allowing one parent to be present both day and night, whereas 59% of units did not allow the constant presence of a parent, even during the day. About half (52%) of PICUs had two daily visiting slots, and 44% allowed more visitors.

**Procedures and Cardiopulmonary Resuscitation.** In 38% of PICUs, parents were not normally allowed to be present at the bedside during ordinary nursing procedures, such as endotracheal suctioning. In the case of invasive procedures, such as inserting a central venous catheter and in the case of cardiopulmonary resuscitation, the presence of parents was permitted only in 3% and 9% of units, respectively.

**Table 2. Furniture in waiting room and facilities for family members and visitors**

<table>
<thead>
<tr>
<th>PICUs, n</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Furniture in waiting room</strong></td>
<td></td>
</tr>
<tr>
<td>Waiting Room</td>
<td></td>
</tr>
<tr>
<td>Seats</td>
<td>17</td>
</tr>
<tr>
<td>Armchairs</td>
<td>11</td>
</tr>
<tr>
<td>Lockers for personal effects</td>
<td>11</td>
</tr>
<tr>
<td>Magazines and books</td>
<td>6</td>
</tr>
<tr>
<td>Drinks machines</td>
<td>5</td>
</tr>
<tr>
<td>Snack machines</td>
<td>2</td>
</tr>
<tr>
<td>Facilities for Family and Visitors</td>
<td></td>
</tr>
<tr>
<td>Bathroom/use of the PICU’s bathroom</td>
<td>14</td>
</tr>
<tr>
<td>Kitchen/use of the PICU’s kitchen</td>
<td>1</td>
</tr>
<tr>
<td>Access to the hospital canteen</td>
<td>16</td>
</tr>
</tbody>
</table>

**Figure 1. Daily visiting time for parents. PICUs, pediatric intensive care units.**

**Table 2. Furniture in waiting room and facilities for family members and visitors.**

- **Gowning Procedures and Hand Washing.** A gowning procedure was compulsory for visitors in 94% of PICUs (Fig. 2). In all units, visitors were required to wash their hands on entering and leaving the unit.

- **Revision of Visiting Policies.** In 11 (32%) PICUs, there was a working group for the periodical revision of visiting policies, and in 16 (48%) units, a formal process of revising the ward’s visiting policies was ongoing.

- **Visiting Time and General Attitudes Toward Visitors.** A longer visiting period (>300 mins) was significantly associated (Table 3) with abolition or simplification of gowning procedures (p < .01).

- **Determining Factors for Opening Times.** Visiting time seemed to be independently associated with the type of PICU. Cardiac surgery units were less likely to have visiting hours >300 mins/day (odds ratio, 0.13; 95% confidence interval, 0.19–0.92; p = .041).

- **Informing Parents.** On admission of the patient, in 77% of cases, the family was given informative material on the PICU (A4 sheet, 33%; leaflet, 18%; booklet, 21%). Daily meetings of doctors with parents were held systematically in almost all PICUs (97%) and were mainly conducted by the physician on duty (68%) and/or unit head (35%). In 79% of PICUs, a room was specifically provided for meetings with family members.

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nosis, prognosis, and treatment, were given in 23% of PICUs. Frequently (often or always, 85%) the family was given the unit’s extension number, and 23% of units had a specific time slot for taking relatives’ phone calls.

**DISCUSSION**

Despite the many objections (9) considered valid until recently (mainly infection risks, interference with patient care, increased stress for patient and family members, violation of confidentiality), there is no sound scientific basis for limiting visitors’ access to critical care units (4, 5). Physicians and nurses often underestimate the needs for mutual closeness of patients and family (9), but there is now wide consensus that the liberalization of visiting in the ICU/PICU is a useful and effective strategy to respond to the needs both of patients and their families (4, 5, 10). It has, therefore, been recommended that visiting in the PICU should be open to parents 24 hrs a day (10). However, the literature gives an inhomogeneous picture of visiting policies in the critical care setting. The latest available percentages of adult ICUs without restrictions on visiting hours are 70% in Sweden (11), 32% in the United States (12), 23% in France (13), 22% in the United Kingdom (14), 3.3% in Flanders (Belgium) (15) and only 0.4% in Italy (8).

With regard to PICUs, a U.S. study (7) in 1994 showed that 57% of 125 units restricted visits to brief daily periods. Another North American study (6) found that eight of 12 PICUs limited visits to varying extents and that only two had an unrestricted visiting policy.

We were unable to find more recent data specifically relating to visiting policies in PICUs, which could indicate that the liberalization of parental presence at the child’s bedside has, from the late 1990s, gained wider acceptance. However, in southern Europe, it seems that, to some extent, there persists a restrictive attitude toward the presence of parents in the unit. A Spanish survey (16) showed that 87% of parents wanted more time to be with their child in the PICU. A European survey (17) on parental visiting in neonatal ICUs showed that, in Italy and Spain, only about 30% allowed unrestricted visiting.

This survey—to date, the first nationwide study on visiting policies and parental presence in the pediatric critical care setting—has five main findings. First, there is a marked and widespread tendency in Italian PICUs to maintain restrictive visiting policies and not to allow 24-hr access of parents at bedside. This is, to some extent, in line with the prevailing restrictive tendency in Italy regarding visiting policies in adult ICUs (8). However, we should point out that, in Italy, PICUs on the whole have less restrictive policies than general ICUs. In particular, in PICUs, the mean visiting time is appreciably greater, there is more willingness to liberalize visiting in the case of a dying patient, and a revision of current policies is underway at a greater proportion of units.

Critical illness and admission to the PICU are important stressors both for children and for parents, capable of inducing stress-related symptoms that may persist even months later (18–21). However, mothers allowed unrestricted visiting in the PICU had significantly lower anxiety scores than those who were restricted (22). No specific data are available for the pediatric setting, but it is worth noting that liberalization of visiting in the adult ICU can significantly lessen patients’ anxiety and hormonal stress indicators (23). Parents are not “visitors” (24); liberalizing parental presence at the bedside can contribute not only to reducing anxiety levels but also to better preserving the parent-child relationship and the parental role. Finally, it can effectively address the most important needs of parents—to be with their child and receive accurate information about his/her condition (25).
Our second finding was that there is a clear tendency to limit substantially the presence of parents during procedures (even ordinary nursing ones) and cardiopulmonary resuscitation. This tendency may reflect the persisting “paternalism” of Italian PICU staff and their lack of experience in working in full view of a patient’s family. This topic has recently been reviewed by Dingeman et al (26). Most parents wish to have the option to remain with their child during invasive procedures and resuscitation, and those who have done so would repeat their choice in the future. Parents can calm or emotionally support their child and help caregivers. Furthermore, decreased anxiety and help with the grieving process are two of the main benefits for allowing parents to be present during procedures or resuscitation. Although the presence of family members during resuscitation has been recommended (27), it is not unani-
mously considered a positive thing and continues to raise concerns among physicians and nurses (28, 29).

Third, cardiac surgical PICUs are more likely to have restrictive visiting hours. We are not aware of analogous findings in the literature, and we conjecture that this attitude may be attributable to the fear that the presence of visitors increases the likelihood of postoperative septal complications—one of the most feared risks after heart surgery (30). This concern is not, however, justified by any scientific evidence (23, 31); for patients, the most significant external risk for infection is from nurses and doctors (4).

Fourth, information provision is well addressed and seems on the whole more extensive than in Italian adult ICUs (8). In particular, there was a greater availability of information tools, parents were given the unit’s extension number more often, and information (including detailed clinical data) was given over the telephone more frequently. These aspects are not merely secondary (25); the use, for instance, of a simple tool like an information pamphlet can significantly improve families’ comprehension and satisfaction (32).

Finally, roughly a third of PICUs did not have a waiting room, and facilities for visitors were poor. Undoubtedly, practical elements may also come into play, such as lack of space; Italian hospitals have a high average age, as 57% of them have been built before 1940 (8). Nevertheless, although the problem of insufficient space was raised by a majority of ICUs surveyed in the United Kingdom (14), they still had significantly more liberal policies. Overall, these data may indicate that, in Italian PICUs, there is still limited attention to the comfort of families of patients. Comfort is among the major needs of families who have critically ill loved ones (9), and it has been recommended that a suitably equipped waiting area should be provided near every ICU (33).

A strength of this study was the high (100%) response rate, which makes us confident that its findings are fully representative of the picture in Italy today. However, certain limitations must be acknowledged. First, we assessed only the actual policies and not the motivation behind them. Second, we should recognize that, although formally restrictive, the policies of some units may sometimes be adapted to specific situations, as in the case of a dying patient.

CONCLUSIONS

From the picture outlined in this study, we may deduce that, in Italian PICUs, the concept of patient and family-centered ICU (10) is still far from being assimilated. There is not yet a full awareness that the presence of parents at the bedside can be useful and beneficial, that it is a child’s right to have parents close at hand during an illness, and that in the critical care setting family members are actually a resource rather than a hindrance (34).

In conclusion, our findings on the whole show a clear tendency in Italian PICUs to apply restrictive visiting policies (although more liberal than in adult ICUs) and to limit substantially the presence of parents during procedures and cardiopulmonary resuscitation. However, it is a positive signal that, in about half of PICUs, a revision of current policies is underway.

ACKNOWLEDGMENTS

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